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WYO-220 (04/08)

OFFICE USE ONLY:
LO#:
BYE:

Medical Provider's Release to Work

Name: _____ SSN: _____

Waiver: I hereby authorize and give my consent to the release of all medical and related information requested and necessary for an eligibility determination of my unemployment insurance claim and any resulting unemployment insurance proceeding. **It is your responsibility that this form be completed by your physician and returned within the time allowed.**

Date: _____ Signature: _____

General Information: The above named individual has filed a new or additional claim for unemployment compensation benefits. The purpose of this document is to provide information used to determine whether or not the claimant meets the criteria of W.S. 27-3-306 (a) (iii), able to work. To assist the Division in determining the individual's potential benefit eligibility, please respond to the following.

1. Primary treating physician information:

   Name: _____

   Address: _____

   Telephone Number: _____

2. This individual has reported to the Division that based on a recommendation from medical authority he/she left his/her employment. Was he/she told to quit working for medical reason(s)? Or, did you advise this individual to stop working for a period of time? If yes, please explain.

   _____

   _____

3. Was there a medical solution that would have allowed this individual to continue working? Yes ____ No ____

   If yes, please explain: _____

   _____

   _____

4. On what date was he/she first advised to stop working? _____

5. Describe the nature of the illness or disability? _____

   _____

   _____

6. List the dates that he/she was not able to work as a result of this particular illness or disability.

   Start date: _____ Date released to work: _____

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7. Is he/she released to full-time work? Yes _____ No _____

   A. If no, is he/she able to work part-time? Yes _____ No _____

8. Is he/she able to return to his/her previous occupation? Yes _____ No _____

   A. If no, explain: _____

   _____

9. Explain any health related limitations that affect the claimant's ability to work at the present time?

   _____

   _____

   _____

   _____

Physician's Signature: _____ Date: _____

Return to:

Wyoming Department of Employment, Unemployment Insurance Division, P.O. Box 2760, Casper WY 82602